STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065228	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon View Care Center	151 E 3rd St Palisade, CO 81526

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#2 and #3) of three residents reviewed for abuse out of three sample residents were kept free from abuse.Specifically, the facility failed to protect Resident #2 and Resident #3 from physical abuse by Resident #1. Findings include:I. Facility policy and procedureThe Abuse policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 8/14/25 at 10:29 a.m. It read in pertinent part, Residents have the right to be free from abuse. This includes but is not limited to freedom from physical abuse. Providing a safe environment for the residents is one of the most basic and essential duties of our facility. Employees have a unique position of trust with vulnerable residents. This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to other residents. Identification of abuse shall be the responsibility of every employee.II. Physical abuse by Resident #1 towards Resident #3 on 5/28/25A. Facility investigationThe 5/28/25 facility abuse investigation documented that at 10:00 a.m. two female residents (Resident #1 and Resident #3) were in the hallway in the secured dementia unit. The nursing staff were providing medications and care to other residents when the staff heard someone yell, Hey! The staff immediately checked and saw that one female resident (Resident #1) was reaching toward and hitting another female resident (Resident #3) in the chest. The staff immediately separated both residents. The investigation documented Resident #3 had two superficial abrasions on her chest with slight redness. Resident #3 was unable to recall the incident. The investigation documented Resident #1 said Resident #3 was after her. Both residents were placed on increased supervision and were in line of sight when they left their rooms. The investigation documented a summary of the staff interviews revealed Resident #3 was agitated prior to the incident and she was unhappy she had to wait for the nurse as the nurse was passing medications. The staff were uncertain if Resident #1 was standing in her doorway or if she was exiting her room, but the incident occurred in the doorway to Resident #1's bedroom. Both residents indicated the other resident attacked them, however, Resident #3 was the only resident with injuries. After the incident Resident #1 calmed down and Resident #3 required one-on-one supervision to calm down. Resident #1 was placed on 15-minute checks for 72 hours. An intervention of line of sight supervision was put into place to prevent a recurrence of the situation.-The facility investigation documented the abuse was substantiated.III. Physical abuse by Resident #1 towards Resident #2 on 6/13/25A. Facility investigationThe 6/13/25 facility investigation documented a female resident (Resident #1) was sitting in the dining room chair watching television. Another female resident (Resident #2) was standing behind her chair next to a certified nurse aide (CNA). Resident #2 put her hand on the back of Resident #1's chair. Resident #1 reached up and said Do not touch me! Resident #1 then grabbed Resident #2's arm using her fingernails, which resulted in three red areas and one superficial open area on Resident #2's right forearm. The (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation documented the CNA stepped between the residents in order to separate them. Resident #1 attempted to hit Resident #2, but the staff prevented the resident from making contact. Resident #1 was asked to go to her room until she was able to calm down, which she agreed to do. The investigation documented a summary of the staff interviews revealed Resident #1 was seated at a table in the main dining room and a CNA was on the right side of Resident #2 as she guided her through the dining room. Resident #2 reached for the back of the chair Resident #1 was sitting in. Resident #2 made contact with the back of Resident #1's chair. Resident #1 did not like being touched and perceived the contact as being hit, as she stated She hit me. Resident #1 reacted with a retaliatory behavior by grabbing Resident #2's forearm, resulting in skin tears and redness. The investigation documented Resident #2 walked independently but needed staff guidance. The investigation indicated the dining room was a little congested with other residents sitting and walkers and chairs. The congestion made Resident #2 navigate around obstacles which resulted in Resident #2 needing to use a chair for either comfort or to steady herself while ambulating. Both residents were placed on 15-minute checks for 72 hours. -The interventions to prevent a recurrence of the situation section of the investigation was not filled out.-The facility investigation documented the abuse was substantiated.IV. Resident #1 (assailant) A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and passed away on 6/20/25. According to the June 2025 computerized physician order (CPO), diagnoses included Alzheimer's disease, paranoid schizophrenia (mental illness) and dementia with psychotic disturbances.According to the 5/1/25 minimum data set (MDS) assessment Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The MDS assessment documented the resident rejected care at times. B. Record reviewResident #1's behavior care plan, revised on 6/30/25, documented the resident had physical aggression, paranoid delusions, dementia and poor impulse control. Pertinent interventions included performing 15-minute checks for 72 hours (initiated 8/29/24), removing or redirecting Resident #1 away from other residents when she was agitated (initiated 9/10/24), conducting medication administration as ordered (initiated 8/6/24) assessing and anticipating the resident's needs (initiated 8/6/24), providing physical and verbal cues to alleviate Resident #1's frustrations (initiated 8/26/24), encouraging Resident #1 to sit with her male friends for meals because she preferred male companionship while eating (initiated 8/30/24), monitoring for any signs of Resident #1 posing danger to herself and others (initiated 8/6/24) and intervening before Resident #1 became agitated and guiding the resident away from sources of distress (initiated 8/6/24).-Review of the resident's care plan did not reveal new interventions were implemented after the resident was involved in two physical abuse altercations.-Review of Resident #1's electronic medical record (EMR) did not include documentation regarding the physical abuse incidents on 5/28/25 or 6/13/25.V. Resident #3 (victim)A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, Resident #3 had a diagnosis of dementia with severe anxiety.The 7/17/25 MDS assessment revealed Resident #3 had severe cognitive impairment per staff interview. The assessment indicated Resident #3 had physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others.B. Record review-Review of Resident #3's comprehensive care plan did not reveal documentation indicating the resident received received physical aggression from Resident #1. -Review of Resident #3's EMR did not reveal documentation regarding the physical abuse incident on 5/28/25.VI. Resident #2 (victim)A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included Alzheimer's disease with late onset and dementia.According to the 5/29/25 MDS assessment Resident #2 had a severe cognitive impairment per staff assessment. The assessment documented Resident #2 did not have any (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors.B. Record reviewResident #2's comprehensive care plan, revised 6/2/25, documented she received physical aggression from another resident. Interventions included assessing and addressing for contributing sensory deficits (initiated 6/2/25), assessing and addressing for contributing sensory deficits (initiated 6/2/25), sitting with the resident and taking her for a walk outside as needed (initiated 6/2/25) and monitoring for any signs of other residents posing danger to the resident (initiated 6/2/25).A progress note, dated 6/13/25, documented a resident (Resident #1) was sitting in the dining room chair as she watched television. Resident #2 stood behind the resident's chair and next to a CNA. Resident #2 placed her hand on the back of the resident's chair. The resident (Resident #1) reached up and said Do not touch me! Resident #1 grabbed Resident #2 by the arm with her fingernails, which resulted in three red areas and one superficial open area on Resident #2's right forearm. The CNA stepped between the residents and separated them. The resident attempted to hit Resident #2 again, but the staff prevented her from making contact. Resident #1 was asked to go to her room until she was calm.VII. Staff interviewsThe memory care director was interviewed on 8/13/25 at 11:20 a.m. The memory care director said the staff on the dementia unit prevented resident-to-resident altercations and behaviors with snacks and a lot of redirection. The memory care director said all staff received dementia training once a year. She said Resident #1 was sometimes volatile but had recently calmed down. She said Resident #1 was good at leaving the area if she was anxious, but often tried hitting others who invaded her personal space. The NHA was interviewed on 8/13/25 at 11:35 a.m. The NHA said it was important to update care plans with new interventions because whatever was previously in place obviously did not work. She said it was important to prevent resident-to-resident abuse to prevent fear or injuries. The NHA said she felt Resident #1 did not instigate the altercations for either incident. The NHA said the root cause of the incident on 6/13/25 appeared to be the dining room was cluttered and Resident #2 got in Resident #1's personal space. The NHA said Resident #3 was the one who was agitated and near Resident #1's doorway on 5/28/25. She said both incidents of abuse were substantiated.